

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05825 77
Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Maple Grove</u> TOWN <u>Maple Grove</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>15-720</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Maple Grove</u> TOWN <u>Maple Grove</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>BRADLEY - M - ARMAROST</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>June 30</u> 19 <u>51</u> (Month) (Day) (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 3 - 1936</u>	9. AGE last birthday <u>15</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
13. FATHER'S NAME <u>Allen R. Ammarost</u>		14. MOTHER'S MAIDEN NAME <u>Leelilah V Bixler</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>✓</u>		17. INFORMANT <u>Allen A. Ammarost, Manchester, Md</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Strangulation

INTERVAL BETWEEN ONSET AND DEATH

4 days 5 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>Suicide</u> SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg, etc.) <u>Home</u> INJURY		(CITY OR TOWN) <u>HAMPSTEAD</u> (COUNTY) <u>Carroll</u> (STATE) <u>MD</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at 6:45p m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Mayme C. Porttford
Army Supt. Examiner

M.D.

1 Longwood

7-2-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 3 - 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		LOCATION (City, town, or county) <u>Carroll Co</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>July 2, 1951</u>		REGISTRAR'S SIGNATURE <u>John S. Hughes</u>		24. FUNERAL DIRECTOR <u>Edw E. Tipton, Hampstead</u>		ADDRESS <u>MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15
T

RECEIVED
JUL 6 1951
BUREAU A. I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05827

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Springs</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>10114 Dallas Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Rose</u>	(Middle)	(Last) <u>Berlinsky</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5/12/90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore - Mar land</u>
13. FATHER'S NAME <u>Samuel Lowery</u>		14. MOTHER'S MAIDEN NAME <u>Mary Benton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT AND ADDRESS <u>Hospital Records</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

420.0

Antecedent cause(s)

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Pneumonia, secondary, undetermined etiology(b) Arteriosclerotic heart disease with(c) decompensation

INTERVAL BETWEEN ONSET AND DEATH

12 hoursIndef.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Decubitus2 months

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 20 1951, to June 24 1951, that I last saw the deceasedalive on June 24, 1951, and that death occurred at 4:00 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Henry H. Chambers

M. D.

Sykesville, Md.6/24/51

23. BURIAL, CREMATION OR REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Final</u>		<u>June 27, 1951</u>		<u>Arlington Hall</u>		<u>Arlington</u>		<u>Va.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>June 25, 1951</u>		<u>Harry Hees</u>		<u>H. H. Chambers Co.</u>		<u>Washington, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 415

RECEIVED
JUN 25 1962
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05826

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 15

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md</u> LENGTH OF STAY (in this place) <u>17 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Longview Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>-</u>	
3. NAME OF DECEASED (Type or Print) <u>Honora</u> (First) <u>Baker</u> (Middle) <u>-</u> (Last)		4. DATE OF DEATH <u>June</u> (Month) <u>21</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 6, 1867</u>
9. AGE last birthday <u>84</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Bedford Co. Pa.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	13. FATHER'S NAME <u>Dennis Sheehan</u>	14. MOTHER'S MAIDEN NAME <u>Ellen Leary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No service</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Joseph E. Baker, Westminster, Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage.</u>			<u>36 hrs.</u>
Antecedent cause(s) (b) <u>Hypertensive Cardio-Renal Vascular Disease?</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>-</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>-</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>-</u>		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE <u>-</u>		INJURY <u>-</u>			
HOMICIDE <u>-</u>					
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-</u>		INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>-</u>	

22. I hereby certify that I attended the deceased from Feb 27, 1950, to June 21, 1951, that I last saw the deceased alive on June 21, 1951, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE <u>Joseph E. Baker, MD</u>		ADDRESS <u>Westminster, Md</u>		DATE SIGNED <u>June 21, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>June 23/51</u>		NAME OF CEMETERY OR CREMATORY <u>Ingos Point Athens, Pa.</u>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster, Md</u>	
DATE REC'D BY LOCAL REG. <u>June 21/51</u>		REGISTRAR'S SIGNATURE <u>Mrs. W. P. Denner</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SYKESVILLE, MD.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRINGFIELD STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>Unknown</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JAMES</u> <u>FRANK</u> <u>BOLIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6</u> <u>22</u> <u>19 51</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>4-26-1869</u>
9. AGE last birthday <u>82</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James P. Bolin</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Jane Cook</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Records, Springfield State Hospital</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Tuberculous pneumonia, right base4 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-7-, 1942, to 6-22-, 1951, that I last saw the deceasedalive on 6-22-, 1951, and that death occurred at 4:20 A.m., from the causes and on the date stated above.SIGNATURE Henry CAM and M.D. Sykesville Md. ADDRESS 922/VJ DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>6-26-51</u>	<u>Rocky Swamp Church Rocky Swamp, S.C.</u>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 23, 1951</u>	<u>C. Harry New</u>	<u>Arthur F. Haight - Sykesville, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105

RECEIVED
JUN 29 1951
BUREAU V. S.
BUREAU V. S.
JUN 29 1951
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05829

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elmow Bridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elmow Bridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Elmow Bridge</u>		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) <u>HELEN R. BROOKS</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 11-1898</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>53</u> yrs. If under 1 year Months Days Hours Min.
10. FATHER'S NAME <u>Joshua Green</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. MOTHER'S MAIDEN NAME <u>Katie Brooks</u>		15. INFORMANT AND ADDRESS <u>Carroll Brooks, Elmow Bridge</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Cardiac Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Hypertension(c) Rheumatic C.V.D.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 1, 1949, to June 30, 1951, that I last saw the deceasedalive on June 29, 1951, and that death occurred at 4:30 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>7/3/51</u>	<u>St. Mary's Cemetery</u>	<u>Elmow Bridge, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>July 7, 1951</u>	<u>Leslie P. Repko</u>	<u>W. H. Bartley & Sons</u>	<u>Elmow Bridge & New Windsor, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 5 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 05830 26

1. PLACE OF DEATH - COUNTY Carroll		STATE Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town) Rural-Westminster Md.		LENGTH OF STAY (In this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
		STREET ADDRESS (If rural, give location) 805 Bradley Street	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
	Benjamin		Brown
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Aug. 26/1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self employed	9. AGE last birthday 55 yrs.
11. BIRTHPLACE (State or foreign country) Anderson Co. S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Brown		14. MOTHER'S MAIDEN NAME Susan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT Moselle Smith 210 King Ct.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Shotgun wound of chest**

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office, bldg., etc.) INJURY **Farm**

(CITY OR TOWN)

(COUNTY)

(STATE)

Rt. 140 2 miles east of Westminster Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY **6-8-51 5:30 P.M.**

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Firearms

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Stanley H. Dinschlag M.D.

700 Fleet Street

6-9-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/12/51

C. V. Dinschlag

Mrs. Katie R. Williams Schroeder St.

510246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

05831

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> TOWN <u>Westminster</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 John St.</u>		MARYLAND LENGTH OF STAY (in this place) <u>60 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> TOWN <u>Westminster</u> STREET ADDRESS (If rural, give location) <u>15 John St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Clude</u> (First) <u>Living</u> (Middle) <u>Buckingham</u> (Last)		4. DATE OF DEATH <u>June</u> (Month) <u>19</u> (Day) <u>1951</u> (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 7 - 1891</u>	9. AGE last birthday <u>60</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus driver - Employer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bus Ridge</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas Buckingham</u>		14. MOTHER'S MAIDEN NAME <u>Mary Henry</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>218-03-3232</u>		17. INFORMANT AND ADDRESS <u>Edie Buckingham 15 John St. Westminster, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of rectum

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Cirrhosis of liver

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

May 3, 1951Carcinoma rectum

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 1, 1951, to June 19, 1951, that I last saw the deceasedalive on June 19, 1951, and that death occurred at 4:50 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Julius ChepkoMr. D.88 W Main Westminster Md June 19, 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/20/51June 22-1951Meachowranck Cem. Westminster MdDon Westminster Md625516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 22 1951
U. S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Bc 05832

1. PLACE OF DEATH: COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>819 Edmondson Ave.,</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EDNA</u>	(Middle) <u>MARIE</u>	(Last) <u>COOPER</u>
4. DATE OF DEATH	(Month) <u>JUNE</u>	(Day) <u>13</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov., 27, 1922</u>
9. AGE last birthday <u>28</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Ira (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Deceased</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) _____

Pulmonary TuberculosisNov., 1950

Antecedent cause(s) (b) _____

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY _____ m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from May 31, 1951, to June 13, 1951, that I last saw the deceasedalive on June 13, 1951, and that death occurred at 8:30 P. m., from the causes and on the date stated above.SIGNATURE Elmer P. Sauer(Degree or title) M.D.ADDRESS Henryton, MarylandDATE SIGNED 6/13/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-18-51</u>	NAME OF CEMETERY OR CREMATORY <u>mt. Zion Cem.</u>	LOCATION (City, town, or county) <u>Baltimore, Md</u>	(State) _____
DATE REC'D BY LOCAL REG. <u>6/12/51</u>	REGISTRAR'S SIGNATURE <u>Albert R. Sauer</u>	24. FUNERAL DIRECTOR <u>Mrs. Katie Williams</u>	ADDRESS <u>322 N. Charles St</u>	

Deputy Local

720836 st

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 19 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05833

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 5</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>		STREET ADDRESS (If rural, give location) <u>951 N. Durham Street</u> ✓	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ESTHER</u> <u>PAULINE</u> <u>CORNISH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>26</u> <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Dep.</u>	8. DATE OF BIRTH <u>Jan., 5, 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning</u>	9. AGE last birthday <u>38</u> yrs.
11a. BIRTHPLACE (State or foreign country) <u>Goldenhill, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Clarence Meekins</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Lane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>214-07-9406</u>	
17. INFORMANT AND ADDRESS <u>Deceased</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

Nov., 1935

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 26....., 1950., to June 26., 1951., that I last saw the deceasedalive on June 26., 1951., and that death occurred at 6:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 30 1951</u>	<u>Bethel Cemetery</u>	<u>Dorchester</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/26/51</u>	<u>Albert R. Durham</u>	<u>James H. Bigham</u>	<u>Co. Contributed and 690408</u>	

Deputy Local

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 20 1961
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05834

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Washington, D. C.</u> COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville</u> LENGTH OF STAY (In this place) <u>since 3/29/44</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>4716 Blagden Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frank</u> (Middle) <u>P.</u> (Last) <u>DRONEY</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3/8/70</u>
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lithographer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Martin Droney</u>		14. MOTHER'S MAIDEN NAME <u>Unknown MARY DORSEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Records - Springfield State Hospital</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Edema of lungs2-3 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic myocarditis and myocardial degeneration1/2 year

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Psychosis with cerebral arteriosclerosis7 years

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>---</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>---</u>	(CITY OR TOWN) <u>---</u>	(COUNTY) <u>---</u>	(STATE) <u>---</u>
SUICIDE <u>---</u>	INJURY <u>---</u>			
HOMICIDE <u>---</u>				
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>---</u>		

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to June 12, 1951, that I last saw the deceasedalive on June 12, 1951, and that death occurred at 10,25 am., from the causes and on the date stated above.SIGNATURE Martin Gross, M.D. (Degree or title)ADDRESS Sykesville, Maryland DATE SIGNED June 12, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-16-51</u>	NAME OF CEMETERY OR CREMATORY <u>ABBEE MAUSOLEUM</u>	LOCATION (City, town, or county) <u>ARLINGTON</u>	(STATE) <u>VA.</u>
DATE REC'D BY LOCAL REG. <u>June 14, 1951</u>	REGISTRAR'S SIGNATURE <u>C. Harry Keen</u>	24. FUNERAL DIRECTOR <u>Harry A. Farley - Catonsville, Md.</u>		ADDRESS <u>---</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

571 459

Lb. 11

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05835

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY ALLEGHANY			
CITY (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE, MD.				CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND			
TOWN SPRINGFIELD STATE HOSPITAL				TOWN CUMBERLAND, MARYLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) 601 N. MECHANIC STREET			
3. NAME OF DECEASED (First) CHARLES (Middle) ARTHUR (Last) DUCKWORTH				4. DATE OF DEATH (Month) 6 (Day) 21 (Year) 1951			
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SEPARATED		8. DATE OF BIRTH JUNE 15, 1902	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday 49 yrs.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME CHARLES DUCKWORTH				14. MOTHER'S MAIDEN NAME ELLA SHROYER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service) -----				16. SOCIAL SECURITY No. UNKNOWN		17. INFORMANT AND ADDRESS RECORDS OF SPRINGFIELD STATE HOSPITAL	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Bleeding from perforated stomach ulcer						About 1 hr	
Antecedent cause(s) (b) chronic alcoholism with						more than	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) paranoid psychosis.						11 yrs.	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION ---				19b. MAJOR FINDINGS OF OPERATION ---			
21. ACCIDENT (Specify) SUICIDE				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			
HOMICIDE ---				(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY ---				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 1, 1947 , to June 21, 1951 , that I last saw the deceased alive on June 15, 1951 , and that death occurred at 6:30 A.m. , from the causes and on the date stated above.							
SIGNATURE Martin Gross, M.D.				DATE SIGNED June 12, 1951			
ADDRESS Sykesville, Maryland				23. BURIAL, CREMATION, REMOVAL (Specify) Removal			
DATE REC'D BY LOCAL REG. June 27, 1951				REGISTRAR'S SIGNATURE Stanley Keen		24. FUNERAL DIRECTOR Frances A. Hensley	
NAME OF CEMETERY OR CREMATORY University Med School				LOCATION (City, town, or county) (State) Beth City Md			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970 000

RECEIVED
JUN 20 1961
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05836

Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY <u>Carroll</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and OR nearest town) <u>Rural Westminster</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. 4</u>				STREET ADDRESS <u>R.D. 4</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM ADOLPHUS</u>		(First) <u>W</u> (Middle) <u>E</u> (Last) <u>BANGH</u>		4. DATE OF DEATH <u>June 29</u> 19 <u>51</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-14-1883</u>	9. AGE last birthday <u>67</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>inform</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Adolphus Reiss E. Bangh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Wingling</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Frank Martin Bangh R.D. 4</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral EmbolismINTERVAL BETWEEN
ONSET AND DEATH3 days

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

Arteriosclerotic Heart Disease5 yrs

(c)

Congestive Heart Failure1 yr

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1951, to June 29, 1951, that I last saw the deceasedalive on June 28, 1951, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. N. HoardM.D.Manchester, Md6/30/5123. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG. 6/30/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Funeral HomeJuly 1-1951Funeral Home Westminster, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

05837

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Sykesville Md</u> LENGTH OF STAY (in this place) <u>24 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>JAMES</u>	(Middle) <u>J.</u>	(Last) <u>EGAN</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>22</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1879</u>
9. AGE <u>72</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steward</u>	11. PLACE OF BIRTH (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Edward B. Egan</u>	14. MOTHER'S MAIDEN NAME <u>Ellen Lyons</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT AND ADDRESS <u>Records of Springfield State Hospital</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic hypertensive cardiovascular disease with failure</u>		<u>10 yrs</u>
Antecedent cause(s) (b) <u>disorders with failure</u>		<u>30 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1, 1927, to 6/22, 1951, that I last saw the deceased alive on 6/22, 1951, and that death occurred at 7:00 p.m., from the causes and on the date stated above.

SIGNATURE Harry Ed Mead M.D. ADDRESS Sykesville Md DATE SIGNED 6/23/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF June 26, 1951 NAME OF CEMETERY OR CREMATORY New Cathedral LOCATION (City, town, or county) BALTO (State) Md

DATE REC'D BY LOCAL REG. 6/25/51 REGISTRAR'S SIGNATURE A W Hedrick GENERAL DIRECTOR CHAS F. EVANS ADDRESS 118 N Mt. Royal

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

05838

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS <u>---</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elmer</u>	(Middle) <u>---</u>	(Last) <u>EVANS</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>8/4/80</u>
9. AGE last birthday <u>70</u> yrs.	If under 1 year Months <u>---</u> Days <u>---</u>	If under 24 hrs. Hours <u>---</u> Min. <u>---</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>light chores</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13. FATHER'S NAME <u>Augustus Evans</u>		14. MOTHER'S MAIDEN NAME <u>Mary Norwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Records - Springfield State Hospital</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Chronic myocarditis and myocardial degeneration3 years

Antecedent cause(s)

(b) Arteriosclerosis10 yrs. (?)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) ---

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Mental deficiency70 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY --- m.INJURY OCCURRED While at Work ☐ Not While At work ☐HOW DID INJURY OCCUR? ---22. I hereby certify that I attended the deceased from Sept. 1, 1947, to June 3, 1951, that I last saw the deceasedalive on June 3, 1951, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

SIGNATURE

Martin Gross, M.D.

ADDRESS

Sykesville, Maryland

DATE SIGNED

6/4/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

June 11, 1951C. Harry TalanBarnes A. Hemslay 578 N. Biddle St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 12 1951
BUREAU V. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH- COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>2311 McElderry Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>FRANK</u>	(Middle) <u>B</u>	(Last) <u>FRECKER</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Jan. 10-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>61</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Frecker</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Grace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Record, Springfield State Hospital</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute pulmonary edema

INTERVAL BETWEEN ONSET AND DEATH

5 hours

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypostatic bronchopneumonia1 dayII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing deathHistory of chronic alcoholism with Delirium Tremens ?

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05840

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
5. SEX		6. DATE OF BIRTH	
6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept 2, 1950, to June 24, 1951, that I last saw the deceased

alive on June 24, 1951, and that death occurred at 7-30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	June 27/51	London Ok.	Beets, Ind	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
6/25/51	A W Hedrick	Harry A. Hinkle	4101 Edmondson Ave	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A75/

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05841

Reg. Dist. No. *X*

1. PLACE OF DEATH- COUNTY Carroll County MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Sykesville		CITY (If outside corporate limits, write RURAL and give nearest town) Sykesville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS (If rural, give location) Springfield State Hosp.	
3. NAME OF DECEASED (First) Arthur (Middle) H. (Last) GERMAN		4. DATE OF DEATH June 19 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) DIVORCED	8. DATE OF BIRTH 5-31-83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10b. KIND OF BUSINESS OR INDUSTRY newspaper	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lemuel GERMAN		14. MOTHER'S MAIDEN NAME Eunice PIERCE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY No. /	
17. INFORMANT AND ADDRESS Springfield State Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Coronary occlusion, with myocardial infarction, left ventricle wall**

Antecedent cause(s)

(b) **Hypertensive cardiovascular disease**
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Schizophrenia, paranoid type

19a. DATE OF OPERATION /		19b. MAJOR FINDINGS OF OPERATION /		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY /		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? /	

22. I hereby certify that I attended the deceased from **5** **05** **1947**, to **June 19**, 19**51**, that I last saw the deceased alive on **June 18**, 19**51**, and that death occurred at **12** **a.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 6/22/51		NAME OF CEMETERY OR CREMATORY Lorraine Cem.		LOCATION (City, town, or county) Woodlawn, Md.		(State) Md.	
DATE REC'D BY LOCAL REG. 6/21/51		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR [Signature]		ADDRESS [Address]			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

05842

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> TOWN <u>Westminster</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>56 Madison St.</u>		MARYLAND LENGTH OF STAY (in this place) <u>1 day</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> TOWN <u>Westminster</u> STREET ADDRESS (If rural, give location) <u>178 W. Main St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>CHARLES EMORY GREENHOLTZ</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 21 1951</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 17-1916</u>	9. AGE last birthday <u>34</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brook yard</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Howard Greenholtz</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Senta</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-12-2547</u>		17. INFORMANT AND ADDRESS <u>Elizabeth Paul Greenholtz Westminster, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Atrophy, Premature (Osteoporosis)

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

20 monthsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>May 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>Osteomyelitis localized Rt Parietal = Dislocation of Ventricle</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 15 July, 1950, to 21 June, 1951, that I last saw the deceasedalive on 21 June, 1951, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 24, 1951</u>		<u>Meadowbrook Cemetery Westminster, Md.</u>		<u>Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTER'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6/23/51</u>		<u>[Signature]</u>		<u>W. Bankard & Son, Westminster, Md.</u>		<u>Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

970697

RECEIVED
JUN 25 1951
BUREAU V. S.

05843

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural--Gist</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural--Gist</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>R.D. Sykesville</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>WILLIAM K. GRIMES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 4 19 51</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-24-1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	9. AGE last birthday <u>86</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>David Grimes</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Parrish</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sarah Grimes, Sykesville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Myocarditis (Chr)</u>		
Antecedent cause(s) (b) <u>Nephritis (Chr)</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1945, to 6-4-1951, that I last saw the deceased alive on 6-3-1951, and that death occurred at 4:30 A.m., from the causes and on the date stated above.

SIGNATURE W. C. Ismuth M.D. ADDRESS Westminster Md DATE SIGNED 6-5-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>6-6-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Providence</u>	LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>June 5 1951</u>	REGISTRAR'S SIGNATURE <u>Chas M Hewitt</u>	24. FUNERAL DIRECTOR <u>C. M. Waltz</u>	ADDRESS <u>Winfield, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. X13

100105

RECEIVED

JUG 9 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05844 71

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Uniontown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Uniontown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Street</u>		STREET ADDRESS (If rural, give location) <u>Main Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>FRANK</u> (Middle) <u>H</u> (Last) <u>HAINES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 21</u> 19 <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>1/7/1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner + Operator</u>		10h. KIND OF BUSINESS OR INDUSTRY <u>Store</u>	9. AGE last birthday <u>64</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Levellin Haines</u>		14. MOTHER'S MAIDEN NAME <u>Emma Barbara Haines Formwalt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>MAID S HAINES, Uniontown</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>443X</u> Antecedent cause(s) <u>93d</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(a) <u>Cerebral Hemorrhage</u> (b) <u>Arteriosclerotic C-V disease & Hypertension</u> (c)	<u>4 years</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1950, to June 21, 1957, that I last saw the deceased alive on June 20, 1957, and that death occurred at 7 A.m., from the causes and on the date stated above.

SIGNATURE <u>James T. March</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Westminster Md</u>	DATE SIGNED <u>June 28/57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 23-1957</u>	NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery Uniontown</u>	LOCATION (City, town, or county) (State) <u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>June 23, 57</u>	REGISTRAR'S SIGNATURE <u>Margaret H. Ingles</u>	24. FUNERAL DIRECTOR <u>Ed Hartley & Sons</u>	ADDRESS <u>New Windsor & Union Bridge, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A11

RECEIVED
JUL 10 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Psc 05845

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 31,</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>121 N. Bond Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>LEON</u> <u>JOHNSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 12 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 30, 1904</u>
9. AGE last birthday <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motorman</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Baugh's Chemical Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>218-03-7700</u>		17. INFORMANT AND ADDRESS <u>Deceased</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Pulmonary Tuberculosis</u>		<u>Dec., 1948</u>
Antecedent cause(s) (b) <u>Heart Condition</u>		<u>May, 1951</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 24, 1949, to June 12, 1951, that I last saw the deceased

alive on June 12, 1951 and that death occurred at 1:55 P. m., from the causes and on the date stated above.

SIGNATURE Elmer P. Lawer M.D. (Degree or title) ADDRESS Henryton, Maryland DATE SIGNED 6-12-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/13/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Salem</u>	LOCATION (City, town, or county) (State) <u>Brooklyn Md</u>
DATE REC'D BY LOCAL REG. <u>6-12-51</u>	REGISTRAR'S SIGNATURE <u>Albert R. Swankham</u>	24. FUNERAL DIRECTOR <u>Elroy C. Wilson</u>	ADDRESS <u>1000 Brooklyn Ave.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16-1

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

05846

1. PLACE OF DEATH: COUNTY <u>Cornell</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>3904 Canterbury Road</u>	
3. NAME OF DECEASED (Type or Print) <u>LAURANCE</u> (First) (Middle) (Last) <u>JONES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 17 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>9/6/77</u> AGE last birthday <u>73</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
13. FATHER'S NAME <u>Wm Henry Jones</u>		14. MOTHER'S MAIDEN NAME <u>Laura King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Hospital records</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Acute exacerbaton3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic arterio sclerotic heart diseaseIndefinite(c) Pulmonary Tbc. arrestedabout 10 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Psychotic cerebral arterio sclerosis57 yrs

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9/24, 1948, to 6/17, 1951, that I last saw the deceased alive on 6/17, 1951, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Henry C. H. Sad M.D. Sykesville, Md6/17/51

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Funeral</u>		<u>6-20-51</u>		<u>London Park</u>		<u>Baltimore, Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>June 17, 1951</u>		<u>C. Harry Warr</u>		<u>Wm Cook, Inc. 1217 St Paul St.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 21 1951
BUREAU V. S.

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		COUNTY	
Carroll		Maryland		Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Sykesville		TOWN Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural, give location)	
Springfield State Hospital					
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)	
Amelia					
4. DATE OF DEATH		(Month)		(Day)	
June		1		19 51	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
female		white		single	
8. DATE OF BIRTH		9. AGE last birthday		10. BIRTHPLACE (State or foreign country)	
9/14/66		84 yrs.		Germany	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?		Germany	
Germany		Germany			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
?		?		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
No		✓		Springfield State Hospital records	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Coronary embolism				1 hour	
Antecedent cause(s) (b) Arteriosclerosis				9 yrs.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Senile psychosis				9 yrs.	
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	
SUICIDE		INJURY		(COUNTY)	
HOMICIDE				(STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from July 1, 1950, to June 1, 1951, that I last saw the deceased alive on June 1, 1951, and that death occurred at 6:15 A.M., from the causes and on the date stated above.					
SIGNATURE		ADDRESS		DATE SIGNED	
Walter H. Soucieffels M.D.		Springfield State Hospital		6/1/51	
Sykesville, Maryland					
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Removal		University Med School		Baltimore Md	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
June 1, 1951		Charles H. Keen		Frances A. Hemmley 578 N. Biddle St	

RECEIVED
JUN 6 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05848

Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Smallwood		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Westminster	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS R. 6 (If rural, give location) Smallwood	
3. NAME OF DECEASED (Type or Print) Martha Alice Lockard		4. DATE OF DEATH June 25 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH August 6, 1901
9. AGE last birthday 49 yrs.		10. If under 1 year: Months 25 Days 25 Hours 51 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William S. Creswell		14. MOTHER'S MAIDEN NAME Elizabeth A. Streaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT AND ADDRESS Wm. O. Lockard		Smallwood, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10th, 1951, to June 25th, 1951, that I last saw the deceased alive on June 25th, 1951, and that death occurred at 10:30 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

John R. Byers Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05849 76

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED		8. DATE OF BIRTH	
9. AGE last birthday		10. IF under 1 year	
11. IF under 24 hrs.		12. IF under 24 hrs.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Cardiovascular Renal Disease
Myocardial Degeneration & Valvular Disease
(b) Arterio-sclerotic system
(c) Hypertension

INTERVAL BETWEEN ONSET AND DEATH

1 yr.
several
yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED	HOW DID INJURY OCCUR?			
	While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>				

22. I hereby certify that I attended the deceased from Feb., 1951, to June 2, 1951, that I last saw the deceased alive on June 1, 1951, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
DATE RECD BY LOCAL REG.	REGISTERAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05850

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH- COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and give nearest town) Ridgeville		CITY (If outside corporate limits, write RURAL and give nearest town) Ridgeville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) Rural-- Mt. Airy	
3. NAME OF DECEASED (Type or Print) JAMES T. MAGERS		4. DATE OF DEATH June 27 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 1-1-1887
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 64 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Theolpus Magers		14. MOTHER'S MAIDEN NAME Mary E. Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No. ----	
17. INFORMANT AND ADDRESS N.W. Magers, Mt. Airy, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Acute Cardiac Disease**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Chronic Myocarditis**

(c) **Cardiac Rupture**

INTERVAL BETWEEN ONSET AND DEATH

1 yr

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **April 4, 1951**, to **June 27, 1951**, that I last saw the deceased

alive on **June 27, 1951**, and that death occurred at **3:30** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF 6-30-1951	NAME OF CEMETERY OR CREMATORY Pine Grove	LOCATION (City, town, or county) Mt. Airy, Md.	(State)
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DATE REC'D BY LOCAL REG June 29/51	REGISTER'S SIGNATURE Dr. S. Snyder	24. FUNERAL DIRECTOR C. M. Waltz,	ADDRESS Winfield, Md.
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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970VW

RECEIVED
JUL 3 1961
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05851

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home</u>		STREET ADDRESS (If rural, give location) <u>Main St -</u>	
3. NAME OF DECEASED (Type or Print) <u>Sadie Grace Masenhimer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June-20-1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec-31-1876</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Manchester - Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>John E Masenhimer</u>		14. MOTHER'S MAIDEN NAME <u>Lilla Rachel Warden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>216-09-0697-A</u>	
17. INFORMANT <u>Wm E Masenhimer (Bro) Manchester</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>9 days</u>
Antecedent cause(s) (b) <u>Hyper tension</u>			<u>20 yrs</u>
(c) <u>Diabetes mellitus</u>			<u>15 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 16</u> , 19 <u>51</u> , to <u>June 20</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>51</u> , and that death occurred at <u>2</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Marlene C. Porterford, M.D.</u>		ADDRESS <u>Lamps Key, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June-23-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Reformed Church Cem.</u>		LOCATION (City, town, or county) <u>Manchester - Md.</u>	
DATE REC'D BY LOCAL REG. <u>6/21/51</u>		24. FUNERAL DIRECTOR <u>Stewart & Morrow Co. - Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

T

290716

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05852
Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Westminster about 30 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Westminster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Center St. Eptel.</u>		STREET ADDRESS (If rural, give location) <u>Center St. Eptel.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ETHEL</u>	(Middle) <u>MARIE</u>	(Last) <u>MC GEE</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 16, 1906</u>
9. AGE last birthday <u>44</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>table worker</u>	11. BIRTHPLACE (State or foreign country) <u>Middletown, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Christopher Shettle</u>	14. MOTHER'S MAIDEN NAME <u>Sabah Myers</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-03-3000</u>	17. INFORMANT AND ADDRESS <u>George Mc. Gee, Westminster, Md.</u>		

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Coronary Occlusion</u>		<u>30 min.</u>
420.1 Antecedent cause(s)	(b) <u>Hypertensive Cardio Vascular Disease</u>		<u>5 years</u>
186.2 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>5/22/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Fract. Tibula Closed Reduction</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE <u>Accident</u> HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Home</u>	(CITY OR TOWN) <u>Westminster</u>	(COUNTY) <u>Carroll</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 19-1951 Pm.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Turned ankle on a step.</u>	

22. I hereby certify that I attended the deceased from 5/21, 1951, to 6/4, 1951, that I last saw the deceased alive on 6/4, 1951, and that death occurred at 10 m., from the causes and on the date stated above.

SIGNATURE G. Allen Moulton MD. (Degree or title) ADDRESS Westminster Md. DATE SIGNED 6/8/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>June 7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cemetery</u>	LOCATION (City, town, or county) (State) <u>Rural, Westminster Md.</u>
DATE REC'D BY LOCAL REG. <u>6/25/51</u>	REGISTRAR'S SIGNATURE <u>G. Allen Moulton</u>	24. FUNERAL DIRECTOR <u>J. S. Myers Jr.</u>	ADDRESS <u>Westminster Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

690488

RECEIVED
JUN 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05853

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 23</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>212 N. Amity St.,</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>CARROLL</u> (Middle) (Last) <u>MCGLOTTEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 26 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 30, 1895</u>
9. AGE last birthday <u>55</u> yrs.		10. If under 1 year Months Days Hours Min. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eleven McGlotten</u>		14. MOTHER'S MAIDEN NAME <u>Mary Henley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>II</u>		16. SOCIAL SECURITY No. <u>219-07-5938</u>	
17. INFORMANT AND ADDRESS <u>Deceased</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

Aug., 1950

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF the bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 17, 1951, to June 26, 1951, that I last saw the deceased

alive on June 26, 1951, and that death occurred at 10:28 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>7-2-51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE RECD BY LOCAL REG. <u>6/26/51</u>	REGISTRAR'S SIGNATURE <u>Albert R. ...</u>	24. FUNERAL DIRECTOR <u>Isabel P. Walker</u>	ADDRESS <u>Schneider</u>

Deputy Local 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 19 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05854

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u> LENGTH OF STAY (in this place) <u>11 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Snithers Road.</u>	
3. NAME OF DECEASED (Type or Print) <u>Beulah B. Parks</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 20 1951</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 18 1902</u>
9. AGE last birthday <u>48</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe</u>	10b. KNOWN BUSINESS OR INDUSTRY <u>Tanning factory</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	13. FATHER'S NAME <u>George Snithers</u>	14. MOTHER'S MAIDEN NAME <u>Eliza Holland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY No. <u>212-24-3190</u>	17. INFORMANT AND ADDRESS <u>Russell Sniffed - Sykesville, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Cerebral hemorrhage</u>		<u>3 days</u>
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>83a</u>		
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/17/1951, to 6/20/1951, that I last saw the deceased alive on 6/19/1951, and that death occurred at 3 A. m., from the causes and on the date stated above.

SIGNATURE <u>Mr. E. Martin, M.D.</u>	(Degree or title)	ADDRESS <u>Candallstown, Md</u>	DATE SIGNED <u>6/21/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/22/51</u>	NAME OF CEMETERY OR CREMATORY <u>White Rock</u>	LOCATION (City, town, or county) (State) <u>Sykesville, Carroll, Md.</u>
DATE REC'D BY LOCAL REG. <u>June 21, 1951</u>	REGISTRAR'S SIGNATURE <u>C. Harry Wier</u>	24. FUNERAL DIRECTOR <u>Luther A. Haight - Sykesville, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

690408

RECEIVED
JUN 25 1951
BUREAU W. SC.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05855
Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and give nearest town) Westminster		LENGTH OF STAY 30 years		CITY (If outside corporate limits, write RURAL and give nearest town) Westminster	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 43 W. Main Street				STREET ADDRESS (If rural, give location) 43 W. Main Street	
3. NAME OF DECEASED (Type or Print) Helen Elizabeth		(First) (Middle) (Last) Petry		4. DATE OF DEATH June 7 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 1, 1909	9. AGE last birthday 41 yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harney, Carroll Co. Md.	
13. FATHER'S NAME John A. Harman		14. MOTHER'S MAIDEN NAME Elsie Polson		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. 213-05-1695		17. INFORMANT AND ADDRESS Charles Norman Petry Westminster, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of Ovary

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

Antecedent cause(s)

(b)

*Metastases to Liver & Chest**6 mo*

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

Anemia & Cachexia

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

*Sept 6-1949**Ca. Rt. Ovary & adhesions*Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Sept 1, 1949*, to *June 7, 1951*; that I last saw the deceasedalive on *June 7, 1951*, and that death occurred at *4:30 P.M.* from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTERAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*6/9/51**John R. Byers**John R. Byers**Westminster, Md.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 11 1951
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05856

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lincolnton</u> TOWN <u>Lincolnton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Grimes Nursing Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lincolnton</u> TOWN <u>Lincolnton</u> STREET ADDRESS (If rural, give location) <u>New Windsor Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Eda</u>	(First) <u>B.</u>	(Middle) <u>Richter</u>	(Last)
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>about 82 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. Grace Warner 85 Liberty St. Westminster, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Generalized Arteriosclerosis

Antecedent cause(s)

(b) 450.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Cholelithiasis - wound infection

INTERVAL BETWEEN ONSET AND DEATH

year

19a. DATE OF OPERATION

Apr 20 - 1951

19b. MAJOR FINDINGS OF OPERATION

Cholelithiasis

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office hldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 17, 1951, to June 18, 1951, that I last saw the deceasedalive on June 18, 1951, and that death occurred at 11 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

James T. MorohMDWestminster Md6/20/51

23. BURIAL CREMATION REMOVAL (Specify)

DATE REC'D BY LOCAL REG.

DATE THEREOF

REGISTRAR'S SIGNATURE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

June 21 - 1951WestminsterWestminsterWestminsterMd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05857

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH: COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Taneytown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Taneytown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Charles</u> (Middle) <u>E</u> (Last) <u>Ridinger</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widower</u>	8. DATE OF BIRTH <u>Dec. 10, 1863</u>
9. AGE last birthday <u>87</u> yrs.		10. AGE last birthday (If under 1 year Months) (If under 24 hrs. Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day LABOR</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Ridinger</u>		14. MOTHER'S MAIDEN NAME <u>Susan Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Curtis H. Reid</u>		<u>Taneytown, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

chronic Interstitial Nephritis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

18 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 14, 1950., to June 22, 1951., that I last saw the deceasedalive on June 21st, 1951., and that death occurred at 4 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 23, 1951Arthur M. McHughC.O. FUSS & SONTaneytown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

504246

RECEIVED
JUN 24 1951
BUREAU Y. & S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 78

05858

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>2111 Homewood Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Eva Spangler</u> (First) <u>Romoser</u> (Last)		4. DATE OF DEATH (Month) <u>6-</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-9-1880</u>
9. AGE last birthday <u>70</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander F. Romoser Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Causey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Brother - Alexander F. Romoser Jr.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

1 Day

Antecedent cause(s)

(b)

Generalized Arteriosclerosis

3 Yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 5, 1948, to June 10, 1951, that I last saw the deceased

alive on June 10, 1951, and that death occurred at 12-40A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/13/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>	LOCATION (City, town, or county) <u>Sykesville, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>6/11/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Redick</u>	24. FUNERAL DIRECTOR <u>Wm. J. Pickens & Sons</u>	ADDRESS <u>7208 26th St. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05859

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Baltimore</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ISAAC</u>	(Middle) <u>SHOWELL</u>	(Last) <u></u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 7, 1915</u>
9. AGE last birthday <u>35</u> yrs.		4. DATE OF DEATH <u>June 20, 1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chicken catcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Showell, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Upshur Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Showell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>222-03-2106</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Carrie Showell, Selbyville, Del.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Tuberculous Meningitis

INTERVAL BETWEEN ONSET AND DEATH

June 3, 1951

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 14, 1951, to June 20, 1951, that I last saw the deceased alive on June 20, 1951, and that death occurred at 7:55 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-24-51</u>	NAME OF CEMETERY OR CREMATORY <u>Long Cemetery</u>	LOCATION (City, town, or county) <u>Selbyville, Del.</u> (State) <u>Del.</u>
DATE REC'D BY LOCAL REG. <u>6/20/51</u>	REGISTRAR'S SIGNATURE <u>Albert R. Swankham</u>	24. FUNERAL DIRECTOR <u>Henry H. Watson Inc.</u>	ADDRESS <u>Selbyville, Del.</u>
Deputy Local			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A14

690105

RECEIVED
JUN 25 1967
S. A. MORGAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2X

Bc 05860

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (First) <u>Georgianna</u> (Middle) (Last) <u>Smith</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>1872?</u>
9. AGE last birthday <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elmer Smith</u>		14. MOTHER'S MAIDEN NAME <u>Suzanna Masson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Springfield State Hospital records</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

12 hours

Antecedent cause(s)

(b)

Generalized arteriosclerosis10 years

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 13, 1951, to June 5, 1951, that I last saw the deceasedalive on June 5, 1951, and that death occurred at 3:50 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Springfield State Hospital
Sykesville, Maryland

DATE SIGNED

6/5/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/6/51R. W. JenkinsH. W. Jenkins & Sons Co. 4907 York Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05861

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u> LENGTH OF STAY (in this place) <u>2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Shutted Road.</u>	
3. NAME OF DECEASED (First) <u>Mary</u> (Middle) <u>Orpha</u> (Last) <u>Smith</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 9, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> If under 24 hrs: Hours <u> </u> Min. <u> </u>
13. FATHER'S NAME <u>Phillip H. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sarah J. Harrington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. Howard A. Smith - Sykesville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Congestive heart failure</u>		<u>4 years</u>
414X Antecedent cause(s)	(b) <u>Rheumatic endocarditis</u>		<u>40 years</u>
92C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Paralysis</u>		<u>2 weeks</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Paralysis, left</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov., 1949, to June 22, 1951., that I last saw the deceased alive on June 22, 1951., and that death occurred at 8:55 P. M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE <u>6-25-51</u>	NAME OF CEMETERY OR CREMATORY <u>mt view</u>	LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>
DATE REC'D BY LOCAL REG. <u>June 23, 1951</u>	REGISTRAR'S SIGNATURE <u>C. Harry Shaw</u>	24. FUNERAL DIRECTOR <u>Arthur H. Haight - Sykesville, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 41

RECEIVED
JUN 26 1951
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05862

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greenmount</u> LENGTH OF STAY (in this place) <u>1 year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greenmount</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>NOAH - MILTON - SMITH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 3 1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar 28-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer cotton factory</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Jeremiah Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary A Ruby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>216-10-1814</u>	
17. INFORMANT <u>Nurs Noah M Smith</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Heart Block420.0 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

93d

(b) Arteriosclerotic Heart Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 yr
5 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 1, 1951, to June 3, 1951, that I last saw the deceased alive on June 3, 1951, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
DATE REC'D BY LOCAL REG. <u>June 4, 1951</u>	REGISTRAR'S SIGNATURE <u>John S. Hughes</u>	24. FUNERAL DIRECTOR <u>Edw C Tipton</u>	ADDRESS <u>Hampstead Md</u>

690439

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU V. S.

06481

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Sykesville		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS (If rural, give location) 106 W. North Avenue	
3. NAME OF DECEASED (Type or Print) HELEN (First) ELIZABETH (Middle) STEWART (Last)		4. DATE OF DEATH (Month) June (Day) 20 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE WIDOWED (Specify)	8. DATE OF BIRTH ? about 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Henderson, Jr.		14. MOTHER'S MAIDEN NAME Carrie A. Smallwood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Jack Henderson - Hastings-on-the-Hudson, N.Y.
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Fatty liver			
Antecedent cause(s) (b) Bronchopneumonia			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Pyelonephritis			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Contusion of brain			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) Hospital	
TIME (Month) (Day) (Year) (Hour) OF INJURY 6-20-51 7.45 p.m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR? Fell out of bed. (9-24-51 - ams)	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>William J. ...</i>		DATE SIGNED June 21, 1951	
23. BURIAL, CREMATION REMOVAL, (Specify) Cremation		DATE THEREOF 6/26/51	
NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REG. 6/25/51		REGISTRAR'S SIGNATURE <i>A W Hedrick</i>	
		24. FUNERAL DIRECTOR <i>Wm. J. ...</i>	
		ADDRESS <i>...</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05863

Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> TOWN <u>Westminster</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.D. 3</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> TOWN <u>Westminster</u> STREET ADDRESS (If rural, give location) <u>P.D. 3</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> (First) <u>THEODORE</u> (Middle) <u>STONESIFER</u> (Last)		4. DATE OF DEATH <u>June 26</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 27-1872</u>
9. AGE last birthday <u>79</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Isaac Stonesifer</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Farmer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Ellen Lane Stonesifer Westminster, P.D. 3, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>1 hr</u>
Antecedent cause(s) (b) <u>Coronary Heart Failure</u>		<u>3 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 20, 1942, to June 26, 1951, that I last saw the deceased alive on June 22, 1951, and that death occurred at 10:30 A. m., from the causes and on the date stated above.

SIGNATURE W. W. F. oard ADDRESS M.D. Manchester, Md. DATE SIGNED 6/27/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 27-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Brigade Cemetery</u>	LOCATION (City, town, or county) <u>Westminster</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>6/28/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>H. B. Beard</u>	ADDRESS <u>Westminster, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 70

05864

1. PLACE OF DEATH- COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Middleburg		LENGTH OF STAY (in this place) 2.5 years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Middleburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)
Robert		J	Walden	June	19	51	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year	If under 24 hrs.	
M	W	married	5/10/1871	80 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) horse trainer		10b. KIND OF BUSINESS OR INDUSTRY race horses		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME R.W. Walden		14. MOTHER'S MAIDEN NAME Caroline Bennett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Mary Norris Walden		Middleburg, Md.		18. MEDICAL CERTIFICATION			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Arteriosclerosis C-V disease	years
Antecedent cause(s)	(b) 422.1	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) 93d	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19**46**, to **June 19, 1950**, that I last saw the deceased alive on **June 19, 1951**, and that death occurred at **2 P.M.**, from the causes and on the date stated above.

SIGNATURE James P. Shure M.D.		ADDRESS Winterville Md		DATE SIGNED 6/20/51	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE 6/22/51	NAME OF CEMETERY OR CREMATORY Middleburg	LOCATION (City, town, or county) Middleburg	(State) Md.	
DATE REC'D BY LOCAL REG. June 23/1951	REGISTRAR'S SIGNATURE Ethel M. Mehring	24. FUNERAL DIRECTOR C.O. FUSS & SON		ADDRESS Tanwytown, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

051859

RECEIVED
JUN 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05865

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rossville Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS <u>Phila Rd + Ridge Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Margaret</u> (Middle) <u>Matilda</u> (Last) <u>Wallace</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3/19/03</u>
9. AGE last birthday <u>48</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Frank Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Ruffing</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Springfield State Hospital records</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral hemorrhage</u>		<u>4 days</u>
331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Generalized arteriosclerosis</u>		<u>1 year</u>
83a (c) <u>Hypertension</u>		<u>?</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/22/, 1950, to 6/29/, 1951, that I last saw the deceased alive on 6/28/, 1951, and that death occurred at 9:00 A.m., from the causes and on the date stated above.

SIGNATURE [Signature] (Degree or title) ADDRESS Springfield State Hosp. Sykesville, Maryland DATE SIGNED 6/29/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>7-2-51</u>	NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>	LOCATION (City, town, or county) (State) <u>Sykesville, Md</u>
DATE REC'D BY LOCAL REG. <u>7-2-51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>John B Connolly</u>	ADDRESS <u>418 Eastern Ave Balto 21</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05866

Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY Carroll CITY (If outside corporate limits, write RURAL and OR give nearest town) Westminster HOSPITAL OR INSTITUTION OR STREET ADDRESS 179 W. Main Street		MARYLAND 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Carroll CITY (If outside corporate limits, write RURAL and give nearest town) Westminster STREET ADDRESS (If rural, give location) 179 W. Main Street	
3. NAME OF DECEASED (Type or Print)	(First) James	(Middle) Pearre	(Last) Wantz
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Apr. 30, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY National Bank	9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Westminster, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles V. Wantz		14. MOTHER'S MAIDEN NAME Caroline V. Pearre	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-9145	
17. INFORMANT AND ADDRESS Jas. Pearre Wantz, Jr. Westminster Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Ventricular Fibrillation****3 hours**

Antecedent cause(s)

(b) **Cardiac failure****24 hours**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) **Hypertensive Cardiovascular Renal Disease****5 years**II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **9 Sept**, 19**49**, to **26 June**, 19**51**, that I last saw the deceased alive on **26 June**, 19**51**, and that death occurred at **12:41 A.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF June 29, 1951	NAME OF CEMETERY OR CREMATORY Krider's Cemetery	LOCATION (City, town, or county) nr Westminster, Md.
DATE RECD BY LOCAL REG. 6/28/51	REGISTER'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR John R. Byers	ADDRESS Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05867 76

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>	
TOWN <u>Westminster</u> LENGTH OF STAY (in this place) <u>about 6 yrs.</u>		TOWN <u>Rural, Westminster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Littletown Road</u>		STREET ADDRESS (If rural, give location) <u>Littletown Road</u>	
3. NAME OF DECEASED (First) <u>HOWARD</u> (Middle) <u>WILSON</u> (Last) <u>WAREHIME</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 5, 1868</u>
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>	
11. FATHER'S NAME <u>David Warehime</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Riggle</u>	
15. SOCIAL SECURITY No. <u>---</u>		16. INFORMANT AND ADDRESS <u>Wilson S. Warehime, Baltimore, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>acute cardiac decompensation</u>		<u>18 hrs.</u>
Antecedent cause(s) (b) <u>arteriosclerosis -</u>		<u>6 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>myocarditis</u>		<u>2 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>---</u>	(CITY OR TOWN) <u>---</u> (COUNTY) <u>---</u> (STATE) <u>---</u>
TIME (Month) (Day) (Year) (Hour) <u>---</u>	INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>---</u>

22. I hereby certify that I attended the deceased from 4-1-51, 1951, to 6-12-51, 1951, that I last saw the deceased alive on 6-12-51, 1951, and that death occurred at 8:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>	DATE <u>June 15, 51</u>	NAME OF CEMETERY OR CREMATORY <u>Meadow Brook Cem. Carroll Co. Md.</u>	LOCATION (City, town, or county) <u>Westminster Md.</u>	(State) <u>Md.</u>
DATE READ BY LOCAL REG. <u>6/14/51</u>	REGISTRAR'S SIGNATURE <u>Charles R. Fouth, M.D.</u>	24. FUNERAL DIRECTOR <u>J. E. Myers, Jr.</u>	ADDRESS <u>Westminster Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05868

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH- COUNTY <u>CARROLL</u> STATE <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural, give location) <u>165 West Main Street</u>	
3. NAME OF DECEASED (Type or Print) <u>ABRAHAM</u> (First) <u>REANO</u> (Middle) <u>WHITEHURST</u> (Last)		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>2/24/91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MADE KHLABLD</u>	9. AGE last birthday <u>60</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Whitehurst</u>		14. MOTHER'S MAIDEN NAME <u>Mary Redsecker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Record, Springfield State Hospital</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Coronary Thrombosis3 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic heart diseaseindefinite

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Psychosis with chronic alcoholism, Deterioration

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4/24, 1951, to 6/1, 1951, that I last saw the deceasedalive on 6/1, 1951, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M. D.Sykesville, Maryland6/1/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>June 4-1951</u>		NAME OF CEMETERY OR CREMATORY <u>TRIDERS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
DATE REC'D BY LOCAL REG. <u>June 2, 1951</u>		REGISTRAR'S SIGNATURE <u>Harry Wees</u>		24. FUNERAL DIRECTOR <u>H. Bankard Son Westminster</u>		ADDRESS <u>Ind</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

510 916

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

05869

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Henryton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>East New Market, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HENRYTON STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>CLEM</u> (First) (Middle) (Last) <u>YOUNG</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>June 12 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Sep.</u>	8. DATE OF BIRTH <u>June 5, 1892</u>
9. AGE last birthday <u>59</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>East New Market, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Stephen Young</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Banks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Deceased</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Pulmonary tuberculosisApr., 1943

Antecedent cause(s)

(b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct. 4, 1943, to June 12, 1951, that I last saw the deceasedalive on June 12, 1951, and that death occurred at 7: A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>June 14, 1951</u>	<u>East New Market</u>	<u>same</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-12-51</u>	<u>Albert R. Swannham</u>	<u>W. B. Hylburg</u>	<u>100105</u>	

Local Deputy

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 10 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bc 05870

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Gamber		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer Park Road		STREET ADDRESS (If rural, give location) 2016 Cliftwood Ave Balto Md	
3. NAME OF DECEASED (Type or Print) Carroll Solomon Zepp		4. DATE OF DEATH June 17 1951	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH Oct 27 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Defense Plant	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Howard S. Zepp		14. MOTHER'S MAIDEN NAME Alverta Gore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 219-01-8857	17. INFORMANT AND ADDRESS 2016 Cliftwood Ave Mrs Marion Moulden Baltimore Md

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Primary Anemia		Splenectomy	1 yr.
293 Antecedent cause(s) (b)			
75c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION Max. 1951		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **6-14-51**, 19**51**, to **6-17-51**, 19**51**, that I last saw the deceased alive on **6-16-51**, 19**51**, and that death occurred at **7 P.** m., from the causes and on the date stated above.

SIGNATURE **M.D. Reisterstown Md** DATE SIGNED **6-19-51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE June 20 1951	NAME OF CEMETERY OR CREMATORY Calvary Meth. Cemetery	LOCATION (City, town, or county) Gamber	(State) Md
DATE REC'D BY LOCAL REG 6/19/51	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Wm Berryman & Sons Reisterstown Md		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

770499

RECEIVED
JUN 22 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05871

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>--</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS <u>Unknown</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Milbourn</u> (First) <u>--</u> (Middle) <u>Zimmerman</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Sep.</u>	8. DATE OF BIRTH <u>11-14-03</u>
9. AGE last birthday <u>47</u> yrs.		10. If under 1 year: Months <u>--</u> Days <u>--</u> Hours <u>--</u> Min. <u>--</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship-yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Howard Victor Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Auschermann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Records - Springfield State Hospital</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Bronchopneumonia</u>		<u>5 days</u>
Antecedent cause(s) (b) <u>Psychosis with Huntington's Chorea</u>		<u>about 6 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1 1947, to June 29 1951, that I last saw the deceasedalive on June 29, 1951, and that death occurred at 8:33 A.m., from the causes and on the date stated above.SIGNATURE Martin Gross, M.D. (Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>6-30-51</u>		<u>Frederick, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>June 30, 1951</u>	<u>C. Harry Wilson</u>	<u>M. R. Fitchison & Son, Frederick, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 44

RECEIVED
JUL 5 1961
BUREAU